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ABSTRACT

The objective of improving mental health care for Hispanics has been reviewed, most often, as dependent upon the provision of culturally sensitive mental health services. "Cultural sensitivity," however, is an imprecise term, especially when efforts are made to put it into operation when providing mental health services to Hispanic clients. Nonetheless, there are values and choices implicit in all treatment innovations, and this paper attempts to order and define these embedded assumptions. The concept of cultural sensitivity as used by researchers and mental health practitioners working with Hispanics is examined, with a focus on three levels: 1) the process of making existing traditional treatment available to Hispanic clients; 2) the selection of therapies that fit the Hispanic culture, or the modification of the treatment modality selected by incorporating into it Hispanic cultural elements; and 3) the development of new modalities based upon an aspect of the client's own cultural context. An example of this third approach is Cuento Therapy, a treatment that takes as its medium the folktales of Puerto Rican culture. Through the relating of these folktales to Puerto Rican children experiencing psychological distress, cultural values are transmitted, the mother's role as socializing agent is reinforced, and pride in the cultural heritage is inculcated. It is believed that ego strengths weakened through the acculturative process can thus be reinstated and reinforced. (GC)

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HISPANICS AND CULTURALLY SENSITIVE MENTAL HEALTH SERVICES

Lloyd H. Rogler, Director
Rena Blumenthal, Research Assistant
Robert G. Malgady, Research Associate
Giuseppe Costantino, Research Associate
Hispanic Research Center, Fordham University

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For the past several years, the Hispanic Research Center (HRC) has been engaged in a research project evaluating the effects of an innovative psychotherapeutic modality known as Cuento Therapy.[1] In this treatment program, New York City Puerto Rican mothers recounted and discussed with their children folktales taken from their ethnic cultural heritage. Cuento Therapy was developed as a culturally sensitive treatment method to bridge the gap between the Puerto Rican cultural heritage and the surrounding Anglo society.

In attempting to fit Cuento Therapy into the broader literature on treatment of Hispanics, we found that there were conceptual implications that extended well beyond this single research project. A variety of programs and therapeutic modalities have been devised to accommodate the perceived mental health needs of Hispanics, but there has been little attempt to identify the theoretical implications of diverse treatment approaches. It is the intent of this article, therefore, to provide an analysis of "cultural sensitivity" as applied in mental health services.

The inadequacies of the mental health delivery system in the United States in relation to the psychological problems of Hispanics have often been noted and widely discussed.[2] There are two theories which proffer explanations of the Hispanics' underutilization of mental health facilities: barrier theory and alternative resource theory. According to barrier theory, anything which keeps the afflicted person away from the agency system or delays contact with that system is, effectively, a barrier to appropriate mental health care. On the side of the mental health agency system, formidable barriers exist, such as prejudice, discrimination, and stereotyping directed at Hispanics; personnel who do not speak Spanish and have little sensitivity to Hispanic values; the location of mental health clinics outside the Hispanic community; and the inability of clinics to deal with the social problems confronted by clients who are not acculturated to American life or who are situated at the bottom of the socioeconomic scale. On the side of the Hispanic client, the barriers are related, in part, to cultural perceptions of mental health issues. Hispanics may perceive mental illness as a stigma or as a medical or spiritual problem and attach little credibility to traditional psychological intervention. Furthermore, they may feel intimidated by the experience of confronting an impersonal bureaucracy in a clinical setting, or may be unaware of the existence of mental health facilities.

The theory of alternative resources explains underutilization in terms of the indigenous Hispanic social organizations serving as therapeutic alternatives to the official mental health agency system. There are a myriad of informal, primary group structures to which Hispanics naturally turn in coping with emotional distress. Primary group structures relevant to mental health care — the family, the circle of friends and acquaintances, the Hispanic *compadrazgo* (coparent) system, religious and spiritualist groups — are an integral part of the Hispanic culture and function alongside the official agency system. They have frequently been conceived as an alternative to the agency system in the provision of psychotherapy and social support.

It is unclear which of these theories plays a greater role in determining whether or not or when Hispanics turn to mental health services in proportion to their population size and their estimated psychological needs. Many of the barriers and alternative resource networks thought to explain Hispanic underutilization also have been used to explain the problems of retaining Hispanics in psychotherapy. Whether the issue is one of attracting clients in need of mental health services or of retaining them in treatment, the underutilization of psychiatric facilities impedes the end objective of improving the mental health care of Hispanics.

The attainment of this objective has been viewed, most often, according to the need for culturally sensitive mental health services for Hispanics. The literature reveals, however, that cultural sensitivity is not a precise term, especially when efforts are made to reduce it to the operational level of providing mental health services to Hispanic clients. Rarely is the term explicitly defined. Nonetheless, there are values and choices implicit in all treatment innovations, and it was these embedded assumptions that we have attempted to order and define. We did not begin with an *a priori* definition of what constitutes culturally sensitive mental health services; rather, we examined how the concept was used by mental health practitioners and researchers in their work with Hispanics. In doing so, we found three broad levels of cultural sensitivity: first, rendering traditional treatment *more accessible* to Hispanic clients; second, *selecting and altering* a traditional treatment according to perceived features of Hispanic culture; and third, *extracting elements from Hispanic culture* and using them as an innovative treatment tool. It is our intention to examine the various issues underlying the concept of cultural sensitivity within these three broad levels.

Level 1: Increased Accessibility to Psychotherapy

The first level of culturally sensitive mental health services involves the pro-

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Stasia Madrigal, Editor, Hispanic Research Center, Fordham University, Thebaud Hall, Bronx, New York 10458. Telephone: (212) 579-2630.

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cess of rendering available to Hispanic clients existing traditional treatment. The issue here is the accessibility of treatment; i.e., the elimination of barriers which prevent Hispanics from receiving treatment. This form of cultural sensitivity may be implemented at the broadest or narrowest developmental level. For instance, it may involve the creation of mental health clinics in Hispanic neighborhoods, or the creation of treatment programs for Hispanics within broader mental health facilities or programs. Such adaptations may be effected in a variety of settings, including community clinics, inpatient units, schools, and social facilities. Accessibility may well be the necessary prerequisite to all forms of cultural sensitivity. In the examples that follow, however, it is implicitly seen as the final goal of treatment modification.

Karno and Morales[3] describe the creation of a mental health clinic especially modified to fit the perceived needs of Hispanics in an East Los Angeles Chicano community. First, Spanish-speaking staff were recruited who were familiar with and committed to the Mexican American community. A site was chosen in the heart of residential East Los Angeles, close to transportation, and in a building with a noninstitutional atmosphere. Preventive services, consultation with other community agencies, and crisis intervention were incorporated into the program along with traditional services. The authors found that "in a context of cultural and linguistic familiarity and acceptance" Mexican Americans responded just as well to traditional treatment as Anglos. This method exemplifies the accessibility model of cultural sensitivity, as implemented on the broadest developmental level.

On an intermediate level of development, programs can be designed specifically for Hispanic needs, but within existing mental health facilities. Scott and Delgado[4] discuss the issues and problems which arose during the creation of a mental health program for Hispanics within a community clinic in Worcester, Massachusetts. The initial effort was ineffective allegedly because the professional supervisor projected traditional views of mental health and displayed little understanding of Hispanic culture. The program was viewed as more effective after the recruitment and orientation of a bicultural and bilingual staff, the integration of the program into the structure of the host facility, and the coordination of the program's efforts with the needs of the Hispanic community.

Cuellar et al.[5] provide an example of a similarly conceived program within an inpatient setting. A ward in a psychiatric hospital in San Antonio, Texas, was designed specifically for Mexican American patients. The staff of this ward were all bilingual and bicultural, the customs and beliefs of Chicanos were integrated into the treatment process, and the ward decor was designed to be congruent with Chicano culture. As these latter examples demonstrate, accessibility may be achieved by the development of programs within existing institutional settings, with the treatment format modeled on those of the host facility or, as the first example illustrates, as an independent facility within the Hispanic community.

In addition to broadly based programs like those above, there are more narrowly delineated efforts specifically designed to render treatment accessible in already established, and otherwise unchanged, mental health programs. Normand et al.[6] describe a group therapy program designed to improve utilization of mental health services in a New York outpatient clinic. The purpose of the group was to provide help for immediate problems and to help patients understand problems in psychosocial terms so that they would use mental health services more readily. Rodriguez[7] provides an example of a similar group in an inpatient setting. This group was targeted toward Spanish-speaking psychiatric patients who were alienated from the hospital system, primarily because of language barriers. The purpose of this group was to acquaint Spanish-speaking patients with the social services provided by the hospital, facilitate community placement, and create a forum for these patients to express their questions and needs. Both of these groups served to make existing services and programs comprehensible and accessible to Hispanic clients.

The lowest common denominator of cultural sensitivity with Hispanics is generally that of linguistic accessibility. Indeed, for many treatment innovators, their primary efforts have focused on hiring bilingual/bicultural staff, thus overcoming the most blatant communication barriers that exist between clients and staff. The importance of even such minimal outreach efforts is dramatized by the innovative use of paraprofessionals devised by Acosta and Cristo.[8] These authors begin with the assumption that Hispanics' demands for mental health treatment are likely to continue to exceed the availability of Hispanic therapists. Accordingly, they proceeded to develop a bilingual interpreter program in a Los Angeles psychiatric clinic located in a large Mexican American community. The interpreters were recruited from the same community as the clients. They were given a training program which sharpened their skills at back and forth translation between Spanish and English and taught them key concepts of psychotherapy and the nomenclature used in clinical settings. At the same time, they acted as cultural consultants, explaining to the English-speaking therapist meanings embedded in the community culture which the patient conveyed during therapy. The interpreters also served as advocates in relation to the Los Angeles service structure. The awkwardness inherent in introducing a third party into the therapy relationship was recognized and discussed by the authors. Nevertheless, the success of this program in increasing accessibility of services was thought to justify the difficulties involved. In recent years, the percentage of Spanish-speaking patients admitted to the clinic has doubled due to their efforts.

It is hardly surprising that the medium through which accessibility is achieved often involves the recruitment of bilingual/bicultural personnel. Although the focus is usually on finding Hispanic professionals, the hiring and training of indigenous paraprofessionals are often considered of almost equivalent value. Such personnel can forge a bridge between the native culture and the clinical services, provide concrete forms of social assistance and clarify to clients the expectations and purposes of the mental health program. At a more personal level, members of the client's own family network can serve a similar purpose.

Thus, one method of increasing cultural accessibility involves incorporating into the mental health system bilingual/bicultural staff, paraprofessionals indigenous to the ethnic community or, at the most personal and direct level, a member of the client's own familial network. In all of these examples, the indigenous ethnic network is socially or structurally intertwined with the mental health system, and the cultural discrepancy between the two is inevitably reduced. The implications of incorporating indigenous personnel into treatment can be further elucidated by exploring the role of the lay referral system in the provision of mental health care.

Eliot Freidson[9] identifies two characteristics of a cultural subpopulation which are likely to influence the utilization of the professional medical system. The first characteristic involves the congruence between the ethnic and

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professional understanding of illness and treatment. Thus, the greater the level of accord between the values of the professional staff and the ethnic client, the more likely it is that the client will seek out professional services. The second characteristic involves the structure and organization of the ethnic group's lay referral system. Lay referral structures are thought to exist on a structural continuum from loose/truncated to cohesive/extended. A loose/truncated referral system allows the individual great leeway in making personal health decisions, whereas a cohesive/extended system pressures the individual to act in accord with the values of the cultural milieu. Freidson believes that the structure and organization of the ethnic group's lay referral system will interact with the level of value congruence to jointly impact on the group's utilization rates.

Using the dual dimensions of congruence and lay referral structure, Freidson believes it is possible to understand utilization rates for various subpopulations, according to where they lie along the two characteristics. The lowest utilization of health services is thought to occur in those communities which have a marked incongruence between cultural and professional values, combined with a cohesive and extended lay referral structure. Such a community's lay referral system would be likely to discourage the use of the professional system, as well as provide alternative routes to coping with health needs in a culturally congruent way.

It is our contention that the Hispanic community largely fits into the latter categorization.[10] The value incongruence can be demonstrated by the fact that many Hispanics view mental illness in somatic terms and attach a stigma to any form of emotional problems.[11] In addition, among Hispanics the lay referral system, which often includes ritual compadres along with an extended family network, exerts a strong and pervasive effect on individual decision-making.[12] Within the Hispanic community, people are unlikely to seek help for personal problems without the guidance and advice of other community members. What is more, the Hispanic community has alternative coping resources, such as spiritism, which are congruent with cultural values, and to which the lay referral system would be likely to guide the individual in distress.[13] According to Freidson's classification system, the Hispanic community would thus be low in value congruence and high in lay referral cohesiveness, and would therefore be likely to manifest low utilization rates of the professional health system.

Thus, a culturally accessible treatment program for Hispanics should be one which increases the congruence between its form of treatment and indigenous values, and one which incorporates members and methods of the lay referral system to further its own purpose. Indeed, there is ample evidence based on both longitudinal and cross-sectional research that such innovations do increase utilization rates in Hispanic communities. For example, Bloom[14] found that the utilization of psychiatric services by Mexican Americans went from underrepresentation in 1960 to overrepresentation in 1970 in Pueblo, Colorado. Two key elements in bringing about this change were the improvement of the image of the mental health system (increasing congruence) and an increase in the number of Chicano staff (incorporating the lay referral system). Trevino et al.,[15] using a cross-sectional approach, found that a community that had reduced linguistic, cultural, and economic barriers to treatment had higher utilization rates for Mexican Americans than would be expected according to census tract figures, and concluded that the underrepresentation of Mexican Americans in community mental health centers reflects barriers to utilization rather than lower need for service" (p. 334). At the minimum, such barriers will include cultural misconceptions and alternative coping resources provided by the lay referral structure.

By reaching out to the ethnic network, the professional system has found that it can interest and attract people to use and retain its services, advance professional conceptions of mental health, and partially bypass alternative coping patterns. At the same time, by incorporating members of the ethnic network into the professional system, key elements of the lay culture are assimilated, thereby inevitably increasing the congruence between the system and the culture. Such elements may include language, cultural allusions, social service assistance, culturally congruent decor, or an easing of transportation and bureaucratic obstacles. On more subtle levels, they may include an ease of communication based on familiarity, shared values, and mutual recognition. What they do not involve is any shift in professional goals, values, or conceptions of mental illness, nor any substantive innovations in treatment format. All such forms of increasing accessibility therefore represent the first general level of culturally sensitive mental health care.

Level 2: Selection or Modification of Traditional Psychotherapy

In addition to treatment accessibility, the actual treatment Hispanics receive in the mental health system has been an additional area of concern which has called for a display of cultural sensitivity. Without such a concern, the logically incongruous but realistic situation could occur wherein Hispanics have greater accessibility to culturally inappropriate therapeutic modalities. This signifies the second level of culturally sensitive mental health care: therapies are selected to fit the Hispanic culture, or the therapy selected is modified by incorporating into it Hispanic cultural elements.

TRAPPED

Puerto Rican Families and Schizophrenia

Lloyd H. Rogler
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There have been some researchers and therapists who have defended the use of psychoanalytic concepts and techniques with ethnic minority clients. Maduro and Martinez[16] present a cogent argument for the value of self-exploration among Hispanics, claiming that "more self-aware individuals are needed to confront insidious social realities in the outer world, as well as unconscious themes in the inner world" (p. 461). In accord with these values, they lead Jungian dream analysis groups, in which the key goal is the development of an integrated ethnic identity. The authors believe that dream work is congruent with Mexican culture because some folkhealers specialize in the analysis of dreams.

Nonetheless, the attitudes of Maduro and Martinez represent a minority opinion, and much criticism has been levelled at insight-oriented psychoanalytic therapy as both uneconomical and irrelevant to the context of Hispanic life. Frontline mental health practitioners working in inner-city, economically depressed Hispanic neighborhoods were among the first to level such criticisms. Their widely shared image of the psychologically distressed Hispanic was of a person pressured and harassed by problems of poverty, slum life, and lack of acculturation. The image of such a client taking his or her place on the psychoanalytic couch for a long-term therapy designed to nurture insight into repressed impulses caricatured psychoanalysis as an absurdly inconsequential and esoteric modality. For this reason, few psychoanalytic therapists sought to address Hispanics' emotional problems, and a pervasive view developed that insight-oriented techniques were too finely calibrated to respond to the massive stresses impinging upon the majority of Hispanic clients.

Bluestone and Vela's work[17] stands as an exception to this pattern of neglect, for they attempt to make proposals, based upon their clinical experience, on how adjustments can be made in the use of insight-oriented therapy with Puerto Ricans living at the bottom of the New York City socioeconomic heap. They stress the following points: the therapist should emphasize the need for the patient to keep appointments on time; the therapist should convey that psychological problems are less clear-cut than medical problems, and that quick cures cannot be expected; the therapist should be authoritative without being authoritarian to avoid transference problems associated with Puerto Rican paternal authoritarianism; therapy should address the Puerto Rican client's tendency to maintain an oversolicitous attitude while acting out hidden aggressive feelings; the therapist should avoid encouraging the client's culturally patterned passive dependency; the therapist should use humor, proverbs, and metaphors to lighten the therapeutic interaction in dealing with common thoughts and feelings; and the therapist should consider the client's culturally patterned difficulties in expressing aggressive feelings. Notwithstanding such adjustment, the authors recognize that suitable candidates for insight-oriented intervention must meet the following qualifications: (1) be relatively free from external chaos; (2) display a persistent motivation to remain in therapy and a long-term outlook on life; and (3) have a capacity for insight. If the therapy is molded to fit the client, the client is also selected to fit the therapy. The authors make an important contribution in their attempt at a difficult task which others have avoided. The issues remain, however, that even with a liberal interpretation of these qualifications, traditional insight therapy would be an inappropriate modality for many members of the high-risk New York City Puerto Rican population.

Before addressing the specific problems of Hispanic populations, therefore, it is worth exploring therapeutic efforts that have been tailored to lower socioeconomic status clients. The work of Minuchin and his collaborators[18] stands as the prototype of how new therapeutic interventions can be developed, sensitively and meaningfully, to address the problems of the most disorganized, disadvantaged slum families. Underlying their efforts is a clear understanding of the sociostructural features of such families: recurring interpersonal dynamics between family members, typical developmental patterns, level of communication skills, and patterns of affectional expression. The development of Minuchin's Structural Family Therapy techniques grew directly out of the articulation and understanding of the patterns that characterize disadvantaged families. An extension of this same philosophy forms the premise for Unitas, a program which has been the object of systematic evaluation[19] at Fordham University's Hispanic Research Center.

Unitas is a therapeutic community in the South Bronx which was developed out of the specific perceived characteristics of the surrounding disadvantaged community. Several hundred black and Hispanic youngsters ranging in age from 5 to 16 participate in the program. About half of the Unitas participants are referred to the program by parents or teachers as "problem children," usually evidencing withdrawn or bizarre behavior. Unitas is founded upon the concept of the family unit as the most important institution that can satisfy a child's needs for nurturance and discipline. It is further assumed that the disintegration of many slum families is at the core of many of the psychological and social problems developed by disadvantaged youth.

In order to counteract the adverse effects of this social disorganization, the Unitas Therapeutic Community tries to compensate for the failures of the real community through a system of symbolic families, each composed of up to 15 boys and girls usually living on the same street. Each symbolic family is headed by one or two older neighborhood teenagers who play the roles of symbolic mother, father, aunts and uncles. These teenagers receive intensive training in psychological therapy and clinical skills and become the primary caretakers and therapists of the younger children, assuming many of the roles and functions that the children's real families have abdicated or lost. The symbolic nuclear families are loosely tied together as a community through extended family circles that meet on a weekly basis to further reinforce positive familial values.

Unitas' highly active system of sanctions, which rewards valued behavior and the mastery of interpersonal skills while discouraging undesirable conduct, creates pressures upon the participants aimed at making the anxious and depressed youngsters less fearful and withdrawn, the acting-out or aggressive youngsters more socially acceptable, and the youngsters with bizarre behavior more attuned to reality. Officially, Unitas youngsters participate in the program one afternoon a week during the school year and, during the summer months, four full days a week. Away from the Unitas meeting place, however, the symbolic parents minister to their "children's" needs as both confront the vicissitudes of life in the South Bronx. Within the innovative community structure, a variety of traditional forms of therapy are employed. Unitas provides individual and family therapy, play therapy, remedial education, sports activities, arts and crafts, and social advocacy for children who require such services. The concept that is unique to the Unitas community, however, is the creation of a symbolic family structure to fill the social gaps in the South Bronx community.

Both Structural Family Therapy and Unitas are integrated treatment programs which respond to the perceived needs of the lowest socioeconomic class into which many Hispanic clients fall. Although most of the features addressed characterize impoverished families generally, other patterns are recognized as aspects of the families' ethnicity. Thus, Puerto Ricans differ from blacks in confronting problems stemming from their unacculturated status and the disparities they experience between their values and language, on one hand, and those which prevail in the host society, on the other hand. Whereas inner-city Puerto Ricans and blacks share many characteristics, such as a family structure that is increasingly based on a single parent and in which siblings operate as the primary socializing agents, there are many crucial distinctions. Minuchin[20] stresses the greater stability of Puerto Rican family roles that emanates from strong cultural traditions and the dynamics of the Anglo-Hispanic culture clash that many Puerto Rican families experience. In the discussion of cultural sensitivity, therefore, it is important to distinguish between treatment adjustments made in the interest of

socioeconomic-related factors as distinct from ethnically based cultural factors; otherwise, the targets of therapy can easily become blurred.

Recognition of the need for new and innovative approaches to the treatment of lower socioeconomic status populations had also led to the selection and adaptation of therapies in accordance with the specific needs of Hispanic clients. In order to effect such modifications, the cultural traits of the clients first must be assessed and, indeed, there is an extensive literature on the special characteristics, values, and needs of Hispanic clients. These Hispanic "traits" are then incorporated into treatment to increase the relevance and efficacy of the therapeutic intervention. What defines this form of cultural sensitivity, therefore, is that an already existing treatment format is adjusted and modified according to a specifically perceived need or trait of a Hispanic population.

Before looking at specific examples of such forms of treatment modification, it is worth noting that individualized treatment selection is an alternative method of achieving the same goals. At the most specific and practical levels of application, culturally sensitive therapy must accord with the needs of the individual client. A broad discussion of cultural traits can easily fall into the trap of stereotypy, disregarding the substantial individual differences in cultural impact and expression. It is in this context that the work of Rene Ruiz[21] is a valuable addition to the elucidation of the concept of cultural sensitivity. Ruiz emphasizes the diversity of subcultures that fall under the catchall phrase "Hispanic," and the further difficulty in identifying who is Hispanic, who is bicultural, and who is sufficiently assimilated to be considered an Anglo. Clearly, treatment decisions cannot be based on simplistic criteria such as Spanish surname, and a patient's preference for a particular treatment is often based on bias and misinformation. Ruiz advocates the assessment of a patient's acculturation prior to therapy and that treatment decisions should be based on valid forms of measurement. He believes that treatment planning, and the decision as to whether culturally sensitive therapy should be provided, should be based on an objective assessment of the degree of biculturalism that the individual client manifests, and he provides rich examples of the integrated treatment plans that may span the continuum from "most Hispanic" to "most Anglo."

An example of how one might use this concept is further provided by Ruiz and Casas[22] in their discussion of a counseling program for Chicano college students. The authors do not assume that all students identified as Chicano are necessarily candidates for a bicultural therapy program. Instead, they define the various forms of "marginality" and "biculturalism" that may be manifest among this population according to the degree of identification with both the minority and majority society. Based on such assessment, they then conclude that it is only those students whose commitment to their own culture is stronger than to the majority culture who are appropriate candidates for the forms of culturally sensitive counseling they propose.

Another example of this relativistic, individualized approach is provided by Gomez and the San Antonio model.[23] Gomez developed a framework for the kind of objective cultural assessment that Ruiz advocates. Through the use of a Cultural Assessment Grid, a typology of four cultural/therapeutic dilemmas is articulated. The need for culturally sensitive treatment is thought to depend on whether the cultural factors are part of the individual or the environment and on whether they contribute to the problem or are resources that can help resolve the problem. Depending on the interaction of these two dimensions, culturally sensitive treatment can mean different things for every individual client, and custom-tailored treatment plans can more easily be constructed, while minimizing the value judgments endemic to the interview process.

Individualized treatment plans can also be derived through the use of personality tests that have been specially tailored to Hispanics. The cultural bias inherent in traditional psychological tests has been well documented,[24] and has deterred some clinicians from their use with minority patients. Nonetheless, there have been sporadic efforts through the years to develop culture-fair diagnostic tools as an aid to the provision of mental health care to minority populations. The recent development of TEMAS, a thematic apperception test designed for urban, minority children that is now being evaluated at the Hispanic Research Center,[25] suggests that culturally sensitive assessment can be achieved through the use of culturally fair psychological instruments. The significance of this research is based on the assumption that individualized and sensitive assessment can provide a useful first step to the development of culturally sensitive treatment decisions.

Nonetheless, despite the acknowledged desirability of individualized treatment plans and sensitive personality assessment, and despite the dangers of stereotyping that arise in the discussion of ethnic traits, generalization about cultural tendencies can provide valuable clinical guides. As the following examples show, the observation of repeated cultural patterns can lead to innovation and increased efficacy of traditional treatment programs.

A clear example of using a specific and common element from the client's ethnic culture in order to complement and modify the provision of conventional therapy is Kreisman's account[26] of treating two Mexican American women schizophrenics who thought of themselves as *embrujada* or bewitched. Kreisman was operating within a traditional psychiatric hospital, in which psychotherapy and medication were the treatments being offered. The relevance and importance of these treatments to the patients' cure were never questioned by ward personnel. The essence of Kreisman's treatment modification was only to concur with the women that they were indeed bewitched, a suggestion which was met with great relief. Encouraging the patients to perform their rituals and take the folk herbs in addition to traditional medications was enough to enable the establishment of a therapeutic rapport which persisted throughout treatment, the topic of folk illness subsequently ceasing to be an issue. Thus, the therapist's acknowledgment of bewitchment and of the need for the techniques of a folk healer broke through the plateau which the conventional therapy had reached, and enabled further therapeutic progress to occur.

Reflecting on this experience, Kreisman formulates three alternative responses to a patient's cultural conception of illness: it may be ignored; it may be accepted as an equal but separate treatment; or it may be encouraged and integrated into the treatment under the control of the therapist. The author advocates the last approach; interestingly, he does not conceptualize the alternative of abandoning conventional treatment and developing a form of folk therapy specific to these patients' needs. Within an inpatient psychiatric setting, this approach might indeed be impossible, although theoretically such an organization would be basic to some alternative forms of cultural sensitivity. In the context of Kreisman's study, the display of cultural sensitivity in treatment means the clear and direct incorporation into the therapist's techniques of elements from the patient's cultural conceptions, without abandoning or compromising the therapist's own conception and therapeutic purpose.

Another example of using a common element of the client's culture is provided by the language-switching techniques employed by Pitta, Marcos and Alpert.[27] These authors note a therapeutic potential within the bilingualism that characterizes most Hispanic clients. They postulate that emotional expression is freer and more spontaneous in one's native tongue, whereas the use of a second language fosters intellectual defenses and inhibits self-disclosure. The language in which therapy is conducted is chosen according to both patient characteristics and phase of treatment, and language-switching is used as a therapeutic technique. The medium into which this technique is incorporated is a traditional, insight-oriented psychotherapy which is in no other way modified for the needs of the ethnic minority client. Like Kreisman, these authors do not change their conception of

their therapeutic role, but utilize a perceived characteristic of their patient population in order to buttress their chosen therapeutic medium.

A third way that culturally sensitive treatment can incorporate an element of the client's culture is through the enactment of culturally familiar roles during therapy, as shown by Maldonado-Sierra and Trent's work[28] with Puerto Rican schizophrenic patients. They used a three-member therapeutic team which was designed to reproduce what they assumed to be the typical Puerto Rican family structure. A senior psychiatrist played the role of the authoritative, dominant, aloof father; a mature psychiatric social worker, the role of a submissive, nurturant, martyr-like mother; and a psychiatric resident, the role of an older sibling who functioned as a bridge connecting the other siblings; i.e., the schizophrenic patients, to the surrogate parents. As an older sibling, the psychiatric resident developed brotherly familiarity with the other siblings, the schizophrenic patients, and served as a "loudspeaker," giving vent to the repressed feelings toward parental authority of the patients, the "children." This familial reenactment is thought to speed the therapeutic process by side-stepping the deep and repressed hostility of Puerto Rican patients to authority figures, which is thought to be a major reason for therapeutic resistance.

Thus, Maldonado-Sierra and Trent have taken a perceived characteristic of Hispanic patients and employed it to facilitate a traditional form of therapeutic intervention, i.e., inpatient group psychotherapy. The cultural characteristic employed is a generalized model of the Puerto Rican family, one which disregards social class and regional variations in the island. Unlike Kreisman and Pitta et al., these authors do not use a cultural characteristic that the patients have already introduced into the treatment, but are instead imposing their own perceptions of Puerto Rican culture onto the client, thus risking the possibility of stereotyped misjudgment. It is to avoid just such forms of stereotypy that authors such as Ruiz[29] and Gomez[30] advocate individualized assessment of cultural status and traits. Clearly, there are both benefits and risks to the utilization of perceived cultural traits in the adaptation and facilitation of established therapeutic modalities.

The examples provided so far designate limited or small-scale adaptations of therapy based on singular aspects of the Hispanic client's culture that have been noted and addressed by clinicians in the field. Far more ambitious and programmatic has been the work of the Family Guidance Center in Miami, which from its inception in 1972, has proceeded with the clear recognition that the demographic, ecological, and cultural attributes of its Cuban constituency had to be understood if the community were to be served through therapeutic interventions.[31] Szapocznik and his collaborators have been exceptionally systematic in thinking their way through the issue of adaptation of treatment modalities to the cultural characteristics of Miami's Cuban population. Their work encompasses broad theoretical issues, controlled research programs, and practical clinical considerations, in an integrated and logically consistent way. Their work begins with research that seeks to determine the Cubans' value orientations and the ways in which such orientations differ from those of other racial and ethnic groups. An attempt is then made to operationalize the concept of acculturation, a problem widely experienced by Miami's Cubans as immigrants from a different sociocultural system. The concept and its measures then form the basis of a theory of intrafamily tension: the greater the disparity in acculturation between family members, the greater the family tensions, the acculturation process tending to occur more quickly in younger persons and males than in older persons and females.

To treat the acculturative problems of Cuban families while being faithful to their cultural value orientations, the researcher-therapists of the Family Guidance Center purposefully introduce adaptations into their therapy of choice, ecological structural family therapy. This therapy integrates the approaches of ecological systems and structural family therapy in order to ". . . permit the therapists to effect reorganization and restructuring by working with and utilizing the client's familial and extra-familial socioecological systems."[32] The selection of family therapy is guided by the familiocentric tradition of Cuban culture, and a therapeutic modality is chosen which coincides with the institutional structure of the client's culture. At all times, the underlying premise is that treatment should ". . . respect and preserve the cultural characteristics of the Latin client."[33]

The point Szapocznik and his collaborators wish to advance is that the treatment utilized should stand in an isomorphic, mirrorlike relationship to the clients' cultural characteristics: ". . . the Cubans' value structure must be matched by a similar set of therapeutic assumptions."[34] The selection of family therapy as the treatment of choice is predicated on the notion that Cubans are family-oriented. Having determined through their research that the Cuban value system prizes lineality, which is ". . . the preference for lineal relationships based on hierarchical or vertical structures . . .,"[35] the family therapist places him- or herself ". . . in a position of authority within the family . . ."[36] in order to restore or reinforce parental authority over the children. Szapocznik and his colleagues outline a detailed sequence of therapeutic interventions, logically deduced from their empirical findings on the values of Cuban clients. Based on a respect for their clients' cultural heritage, this treatment replicates and reinforces essential elements of the Cuban value system and is, therefore, assumed to be culturally sensitive.

Other treatment adjustments with Hispanic clients, however, do not follow such a direct isomorphic pattern. Sometimes treatments are introduced which constitute a dialectical inversion of the assessed characteristics of the client. For example, Boulette[37] notes the frequency of a subassertiveness pattern in Mexican American women, and judges this pattern to be psychologically dysfunctional. Research has demonstrated that this general sex-role pattern prevails in other Hispanic groups; for example, among Puerto Rican women of humble social class it is a reflection of culturally induced conformity, and of the woman being expected to passively accept her lot in life.[38] Boulette has targeted this culturally prevalent pattern as the focus of a therapeutic program that trains Mexican American women to be more assertive. The ultimate purpose of this behavioral training is for the women to overcome the somatic complaints, depression, and anxiety that are thought to result from culturally prescribed submissiveness.

The juxtaposition of the assumptions of Szapocznik and his collaborators with those of Boulette raises critical questions. Once the characteristics of a cultural group have been adequately documented and researched, what should be the treatment? Should it attempt to preserve traditional cultural elements, or should acculturation, assimilation, or adaptation to

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the surrounding society sometimes take priority? Perhaps advocacy on behalf of preserving traditional cultural elements, no matter how well intentioned, should not always or exclusively shape the character of the therapeutic intervention. On the other hand, the values of the host society should similarly not be idealized as reflecting universal standards of mental health. It is our contention that when a therapy is modified to meet the needs of Hispanic clients, it need not isomorphically reflect or counteract the client's cultural characteristics. We hypothesize that therapeutic gains can sometimes be made when traditional cultural patterns are bent, changed, or redirected according to predetermined therapeutic goals.

Thus, the first step in any process of treatment modification is to acknowledge or empirically determine the special ethnic "traits" that exist within a group; this trait-recognition is then transformed into a culturally sensitive treatment. The kind of innovation that emerges depends, however, not only on the ethnic characteristics identified, but also on the value system of the therapist and the therapist's standards of mental health. Isomorphic reinforcement of cultural traits implies a deep respect for the cultural context and an assumption that culturally transmitted ideologies are necessarily adaptive. Isomorphic counteraction, on the other hand, assumes that some cultural traits serve as an obstacle to cultural adaptation, and that assimilation of the values of the host society is an additional and valid standard of adjustment. This approach assumes that cultural elements can be modified within the treatment according to the implicit goals of therapy, without doing violence to their value and purpose as a culturally functional trait. It also assumes that an objective, scientific stance can be adopted not only in terms of the assessment of Hispanic traits, but also in terms of the construction of culturally sensitive treatments.

In order to modify a treatment program according to the needs of a cultural group, hypotheses must be carefully developed to reflect the intricacies of the many possible connections between various cultural traits and the therapies being administered. Research seeking to test such hypotheses may well indicate the value of sometimes preserving and sometimes altering the client's adherence to traditional cultural elements. The ultimate aim should be the adaptation of the Hispanic client to the new host society in such a way that ethnic identity and pride are not negated or belied.

The acceptance of this approach implies that culturally sensitive treatment can recognize and respect cultural values without isomorphically reflecting the qualities of the ethnic milieu. Nevertheless, all of these therapeutic judgments suffer from a lack of rigorous empirical bases. Moreover, they involve a basic adherence to traditional methods, with the cultural adaptations amended in order to facilitate the traditional treatment format. Although there are clear benefits to maintaining established therapeutic conceptions, the question still remains as to whether nonisomorphic, cultural sensitivity can be developed through new and innovative, culturally-specific treatment modalities.

Level 3: Developing a New Treatment Modality from the Culture

So far we have discussed two types of efforts to develop culturally sensitive mental health services for Hispanics. The first involves improving the accessibility of such services by incorporating elements of Hispanic culture. The second involves the selection and alteration of available treatment modalities to fit the Hispanic client's culture. The third effort involves the development of new modalities which take as their point of departure not the existing armamentarium of traditional therapies, but an aspect of the client's own cultural context. A program recently evaluated at the Hispanic Research Center, Cuento Therapy, is an example of a singular and delimited form of treatment developed out of material specific to the Puerto Rican community. It takes as its medium the folktales of Puerto Rican culture. The importance and value of the traditional transmission of such tales is the premise of therapeutic intervention.

Yesterdays' Puerto Rican culture was suffused with the traditions of folktales which were told from one person to another and handed down from one generation to the next. Latin American people have been acknowledged for the richness and importance of their folktale traditions.[39] Among them, however, Puerto Ricans occupy a special place, judging by the results of efforts to collect their folktales. Over 70 years ago, Dr. J. Alden Mason undertook the prodigious task of collecting folktales in the island. He concluded that the collection "... is by far the most abundant and most important Spanish folktale material collected in Spanish America. Its importance for American-Spanish folklore studies is inestimable."[40]

The importance of folktales to the process of cultural transmission has also been recognized by scholars. As parents and grandparents, neighbors and friends, all recounted folktales to the children, the children learned the traditions of their Puerto Rican culture while enjoying the plots of the stories. Bettelheim[41] has written extensively on the role folktales play in the psychological development of children. Arbuthnot,[42] writing on the cultural value of folktales, states:

> *Folktales have been the cement of society. They not only expressed but codified and reinforced the way people thought, felt, believed, and behaved.*

Underlying the development of Cuento Therapy is the assumption that the psychological distress experienced by many children who grow up within an alien culture is partly due to a weakened cultural value system, a sense of distance from the surrounding society, lack of pride in ethnic roots, and the family's diminished role as a cultural agent of socialization. Through the relating of folktales, cultural values are transmitted, the mother's role as socializing agent is reinforced, and pride in the cultural heritage is inculcated. It is believed that ego strengths that are weakened through the acculturative process can thus be reinstated and reinforced.

Throughout Puerto Rican history, as folktales were told and retold they underwent change, with additions and subtractions being made, the stories sometimes bent in one direction or another. Whatever the changes, however, the folktales retained their fidelity to Puerto Rican culture. The malleability of the Puerto Rican folktales was seen as a distinct advantage in the development of Cuento Therapy. Some of the childen who participated in the study were told folktales as they appeared in scholarly listings without alteration. For these children, an isomorphic relationship was established between the child's ethnicity and the cultural values embedded in the therapeutic message. However, since we argue that the value of such an isomorphic relationship should be viewed as a hypothesis, and not as an axiom, other children were exposed to folktales which had been changed in order to convey the knowledge, values, and skills which were deemed useful in coping with the demands of the sociocultural environment of New York City. In this final adaptation, Cuento Therapy embodies the criteria of our final definition of cultural sensitivity.

Nothing precludes Cuento Therapy from forming part of a much broader institutional program incorporating diverse therapies, but as used thus far it has been delimited. The folktales were presented to Puerto Rican children over a short period of time and separately from any other form of therapeutic intervention. This third level of culturally sensitive treatment might also be instituted on a programmatic scale, but it would require greater efforts and greater innovation than the first two styles of cultural adaptation. The development of new therapeutic modalities out of specific cultural traits is an ambitious and difficult task. Efforts to render therapeutic modalities culturally sensitive, no matter how persuasive or attractive they are, must ultimately attend to the final objective of relieving the client of psychological distress and improving his/her level of effective functioning in society. In order to

determine if this has been achieved, research must be conducted. As Padilla et al.[43] stated, ". . . an innovative treatment program is self-defeating unless validating research is conducted . . . to guide the development of programs with the greatest probability of success." It is particularly important that innovative modalities such as Cuento Therapy do not become part of the vast pool of other untested therapies. However, the task of validation should not deter us from the attempt to create new therapeutic programs that stem directly from the cultural milieu of an ethnic clientele.

Conclusions

Three levels of cultural sensitivity have been defined and portrayed, but it must be stressed that these categories are not mutually exclusive. Therapeutic programs and modalities exist on a continuum of cultural sensitivity and cannot be easily pigeon-holed. A program may begin by making minor adjustments that may make the treatment more accessible and, at some point, make so many changes as to be considered a new form of therapy. Moreover, any treatment plan, no matter how innovative, must be located near a Hispanic neighborhood, employ Spanish-speaking staff, and be accessible to the client. Clearly, it would be simplistic to view our definitions as a rigid system of classifying efforts aimed at enhancing the cultural sensitivity of mental health services.

Perhaps a more useful image than that of a continuum would be that of a pyramidal structure. At the base lie the numerous therapeutic programs that have made efforts toward accessibility of mental health services to Hispanic populations. Up the pyramid are those programs which have gone several steps further in this process, choosing treatments according to perceived Hispanic needs and modifying them according to an evaluation of ethnic characteristics. Finally, at the top and most ambitious level of cultural sensitivity are those therapeutic modalities that are derived from the cultural milieu. No progam could possibly accomplish this level of cultural relatedness without a recognition of Hispanic traits and without modifications in the interest of greater accessibility. Although no clear-cut divisions exist between the programs so defined, the distinctions are conceptually useful.

Thus, from our attempt to conceptually order the many uses and meanings of "cultural sensitivity," the concept of therapeutic isomorphism emerges as a major contribution to the field. Rarely are attempts made to empirically delineate and define the values embedded in Hispanic treatment programs. It should no longer be sufficient for a clinician to merely assert cultural sensitivity based on good intentions alone; as an alternative, we invite our colleagues to situate clinical innovations both in terms of level of accessibility and the implicit goals of ethnic affirmation or flexible acculturation. The distinction we have drawn between isomorphic reinforcement and counteraction provides an initial framework for studying these phenomena, and it is our hope that others will supplement and enrich this formulation by applying it to concrete research designs. In the endeavor to provide fair and equal mental health services to the Hispanic minority, explicit hypotheses must be constructed that define and test both the goals and the methods of treatment efforts. It is our belief that if we address the many ramifications of challenging culturally based isomorphic therapies much can be added to such investigations, and thus to the overall adjustment of the Hispanic ethnic community.

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